This document has been prepared by a multiprofessional collaborative group, with support from the All Wales Prescribing Advisory Group (AWPAG) and the All Wales Therapeutics and Toxicology Centre (AWTTC), and has subsequently been endorsed by the All Wales Medicines Strategy Group (AWMSG).

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Management of Persistent Pain

Aims

Highlight the issues surrounding the management of persistent pain conditions and support patients, carers and healthcare teams in understanding the potential benefits and harms of medicines used in pain management.

Provide prescribers with the information needed to support the appropriate management of persistent pain conditions.

Highlight the risks associated with inappropriate prescribing of medicines in pain management.

Definitions

Pain

"Pain is an emotion experienced in the brain, it is not like touch, taste, sight, smell or hearing. It is categorised into Acute pain - less than twelve weeks duration and Chronic pain - of more than twelve weeks.

Pain can be perceived as a warning of potential damage, but can also be present when no actual harm is being done to the body."

British Pain Society

www.britishpainsociety.org/people-with-pain/useful-definitions-and-glossary/#pain

Neuropathic pain

"Neuropathic pain is pain initiated or caused by a primary lesion or dysfunction in the peripheral or central nervous system. For example, pain following shingles, or an amputation, or spinal cord trauma. Pain that occurs in diabetics or in patients with multiple sclerosis can also be neuropathic."

British Pain Society

www.britishpainsociety.org/people-with-pain/useful-definitions-and-glossary/#pain

Persistent Pain

• Persistent pain is complex and can be described as having both sensory and emotional components
  • The only way of deciding whether someone has pain is by asking them or picking up clues from the way they behave
  • There must be a patient-centred holistic approach to persistent pain management
Persistent Pain

Medicines in general and opioids in particular are often not very effective for persistent pain

Prescribers must consider the benefits for the patient balanced against the burdens and risks of long-term use

The position of opioid treatment must be considered within a wider social context, and issues such as diversion must be addressed

Different treatments work for different people

Managing expectations

Not likely to be cured

Not likely to be pain-free

Need to self-manage as with any other chronic condition

Patient needs to be party to the treatment and to take control/responsibility for some of their care

Background

Persistent pain is complex

Opioids are increasingly being used to treat persistent pain

Opioids have a well-established role in the management of acute pain and in the management of pain in terminal illness

However, the safety and efficacy of opioids in the long-term, as well as the risk of tolerance, dependence and addiction, is uncertain

Prescribers must consider the benefits for the patient balanced against the burdens and risks of long-term use

The position of opioid treatment must also be considered within a wider social context and issues such as diversion and misuse must be addressed

Non-pharmacological management of persistent pain

Non-pharmacological therapies and medicines with proven efficacy for persistent pain syndromes should always be tried before starting opioids
Self-management of persistent pain

It has been estimated that people with health conditions (including pain) may spend less than 3 hours a year on average in contact with members of their healthcare team; therefore, the need to improve self-management skills, as well as seeking the help of healthcare professionals, is very important.

Patients often feel helpless and unable to cope with pain themselves.

The Pain Toolkit is a very useful resource to set the scene with patients:

- Acceptance of the pain and recognition of the need to take control is an important part of self-management.
- Goal setting, pacing, planning and prioritising daily activities help patients maintain motivation and increase their activity without causing significant fluctuations in pain levels.
- Relaxation and mindfulness can help ease tension in the muscles and mind.
- In some cases, lack of activity worsens deconditioning to the point where any movement becomes painful; patients should be encouraged to maintain a level of activity.

Prescribing in persistent pain

Prescribing in pain management and opioids

Complete pain relief is rarely achieved with opioids; the goal of pain management should be to reduce symptoms sufficiently to support improvement in physical, social and emotional functioning.

The decision to start long-term opioid therapy should be considered carefully by the patient and the prescriber, and arrangements for long-term monitoring must be in place.

The prescribing of opioids can result in problem drug use and the likelihood of this occurring can be influenced by social, psychological and health related factors.

Any concerns about problem drug use should prompt referral to specialised pain and addiction services.

Resources should be available to prescribers in non-specialist settings to empower clinicians by supporting the evidence-based decisions they make within the complex context of multidisciplinary pain management.

Opioid and other analgesic prescribing breakdown for health boards in Wales, England and NE England April 2015–March 2016

Equivalent doses of opioid analgesics

The following slides provide examples from the BNF of dose equivalence tables of some commonly prescribed opioids.

Equivalence tables may differ locally.

Refer to local guidelines when appropriate.
Fentanyl patch equivalences

<table>
<thead>
<tr>
<th>72-hour fentanyl patches are approximately equivalent to the following 24-hour dose of oral morphine.</th>
</tr>
</thead>
<tbody>
<tr>
<td>morphine salt 30 mg daily</td>
</tr>
<tr>
<td>morphine salt 60 mg daily</td>
</tr>
<tr>
<td>morphine salt 120 mg daily</td>
</tr>
<tr>
<td>morphine salt 160 mg daily</td>
</tr>
<tr>
<td>morphine salt 240 mg daily</td>
</tr>
</tbody>
</table>

*Conversion ratios vary and these figures are a guide only. Morphine equivalences for transdermal opioid preparations have been approximated to allow comparison with available preparations of oral morphine.

Buprenorphine patch equivalences

<table>
<thead>
<tr>
<th>Buprenorphine patches are approximately equivalent to the following 24-hour dose of oral morphine.</th>
</tr>
</thead>
<tbody>
<tr>
<td>morphine salt 12 mg daily</td>
</tr>
<tr>
<td>morphine salt 24 mg daily</td>
</tr>
<tr>
<td>morphine salt 48 mg daily</td>
</tr>
<tr>
<td>morphine salt 84 mg daily</td>
</tr>
<tr>
<td>morphine salt 126 mg daily</td>
</tr>
<tr>
<td>morphine salt 168 mg daily</td>
</tr>
</tbody>
</table>

*Conversion ratios vary and these figures are a guide only. Morphine equivalences for transdermal opioid preparations have been approximated to allow comparison with available preparations of oral morphine.

Opioids

Strong Opioid Prescribing

Strong opioid use as a whole is increasing within NHS Wales

The number of prescription items of strong opioids in Wales has increased by 46%* over the last few years

The number of prescription items for strong opioids increased by 11% over the last year**
Strong opioid prescribing trends for Welsh health boards
Quarter ending December 2009–Quarter ending March 2016

Morphine as a percentage of strong opioid prescribing

Tramadol prescribing trends for Welsh health boards
Quarter ending December 2009–Quarter ending March 2016
Neuropathic agents

Gabapentin and pregabalin prescribing trend for Welsh health boards
Quarter ending December 2009–Quarter ending March 2016

0 200 400 600
DDDs/1,000 patients

800 1000 1200 1400 1600

Aneurin Bevan
Cardiff and Vale
Hywel Dda
Betsi Cadwaladr
ABMU
Powys
Cwm Taf

National Prescribing Indicators

NPIs

2015-2016
Items of morphine as a percentage of strong opioid prescribing
Tramadol DDDs per 1,000 patients

2016-2017
Tramadol DDDs per 1,000 patients
Gabapentin and pregabalin DDDs per 1,000 patients

Online interactive programme for comparative analysis of NPI information
Available at http://howis.wales.nhs.uk/sites3/page.cfm?orgid=428&pid=691
Deaths related to drug poisoning in England and Wales 2014

3,346 drug poisoning deaths were registered in 2014 in England and Wales, the highest since comparable records began in 1993.

Deaths involving heroin and/or morphine increased by almost two-thirds between 2012 and 2014, from 579 to 952 deaths.

Deaths involving tramadol have continued to rise, with 240 deaths in 2014.

In England there was a 17% rise in the drug misuse mortality rate in 2014 to 39.7 per million population, while in Wales the rate fell by 16% to 39.0 deaths per million, the lowest since 2006.

Number of drug-related deaths in England and Wales by substance

<table>
<thead>
<tr>
<th>Substance</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>All drug poisoning deaths</td>
<td>2,747</td>
<td>2,652</td>
<td>2,597</td>
<td>2,955</td>
<td>3,346</td>
</tr>
<tr>
<td>Heroin and morphine</td>
<td>791</td>
<td>556</td>
<td>579</td>
<td>760</td>
<td>942</td>
</tr>
<tr>
<td>Methadone</td>
<td>355</td>
<td>411</td>
<td>420</td>
<td>394</td>
<td></td>
</tr>
<tr>
<td>All amphetamines</td>
<td>56</td>
<td>62</td>
<td>67</td>
<td>165</td>
<td></td>
</tr>
<tr>
<td>MDMA/ECstasy</td>
<td>8</td>
<td>13</td>
<td>31</td>
<td>43</td>
<td>90</td>
</tr>
<tr>
<td>PMA/PMMA</td>
<td>0</td>
<td>1</td>
<td>20</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Novel psychoactive substances</td>
<td>22</td>
<td>29</td>
<td>32</td>
<td>60</td>
<td>67</td>
</tr>
<tr>
<td>All benzodiazepines</td>
<td>307</td>
<td>258</td>
<td>264</td>
<td>342</td>
<td>370</td>
</tr>
<tr>
<td>Quaalude</td>
<td>185</td>
<td>179</td>
<td>207</td>
<td>228</td>
<td>258</td>
</tr>
<tr>
<td>Zopiclone/zolpidem</td>
<td>67</td>
<td>71</td>
<td>83</td>
<td>96</td>
<td>103</td>
</tr>
<tr>
<td>All antidepressants</td>
<td>381</td>
<td>385</td>
<td>446</td>
<td>456</td>
<td>517</td>
</tr>
<tr>
<td>Tricyclic antidepressants (BNF 4.3.1)</td>
<td>194</td>
<td>200</td>
<td>233</td>
<td>230</td>
<td>253</td>
</tr>
<tr>
<td>Selective serotonin re-uptake inhibitors (SSRIs) (BNF 4.3.2)</td>
<td>136</td>
<td>127</td>
<td>158</td>
<td>152</td>
<td>169</td>
</tr>
<tr>
<td>Other antidepressants (BNF 4.3.2 and 4.3.4)</td>
<td>74</td>
<td>84</td>
<td>104</td>
<td>123</td>
<td>155</td>
</tr>
<tr>
<td>Pimozide</td>
<td>199</td>
<td>207</td>
<td>202</td>
<td>226</td>
<td>260</td>
</tr>
<tr>
<td>Tramadol</td>
<td>132</td>
<td>154</td>
<td>175</td>
<td>220</td>
<td>240</td>
</tr>
<tr>
<td>Codeine</td>
<td>91</td>
<td>86</td>
<td>73</td>
<td>130</td>
<td>130</td>
</tr>
<tr>
<td>Diethylamidene</td>
<td>90</td>
<td>109</td>
<td>103</td>
<td>112</td>
<td>86</td>
</tr>
<tr>
<td>Other specified opiate</td>
<td>68</td>
<td>60</td>
<td>65</td>
<td>92</td>
<td>125</td>
</tr>
<tr>
<td>Unspecified opiate</td>
<td>172</td>
<td>137</td>
<td>92</td>
<td>140</td>
<td>169</td>
</tr>
</tbody>
</table>

Telephone enquiries to the National Poisons Information Service (NPIS) 2014–2015

<table>
<thead>
<tr>
<th>Substance</th>
<th>Number of telephone enquiries</th>
<th>Ranked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tramadol</td>
<td>623</td>
<td>8</td>
</tr>
<tr>
<td>Morphine</td>
<td>246</td>
<td>20</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>276</td>
<td>31</td>
</tr>
<tr>
<td>Pregabalin</td>
<td>435</td>
<td>18</td>
</tr>
<tr>
<td>Methadone</td>
<td>74</td>
<td>N/A</td>
</tr>
</tbody>
</table>